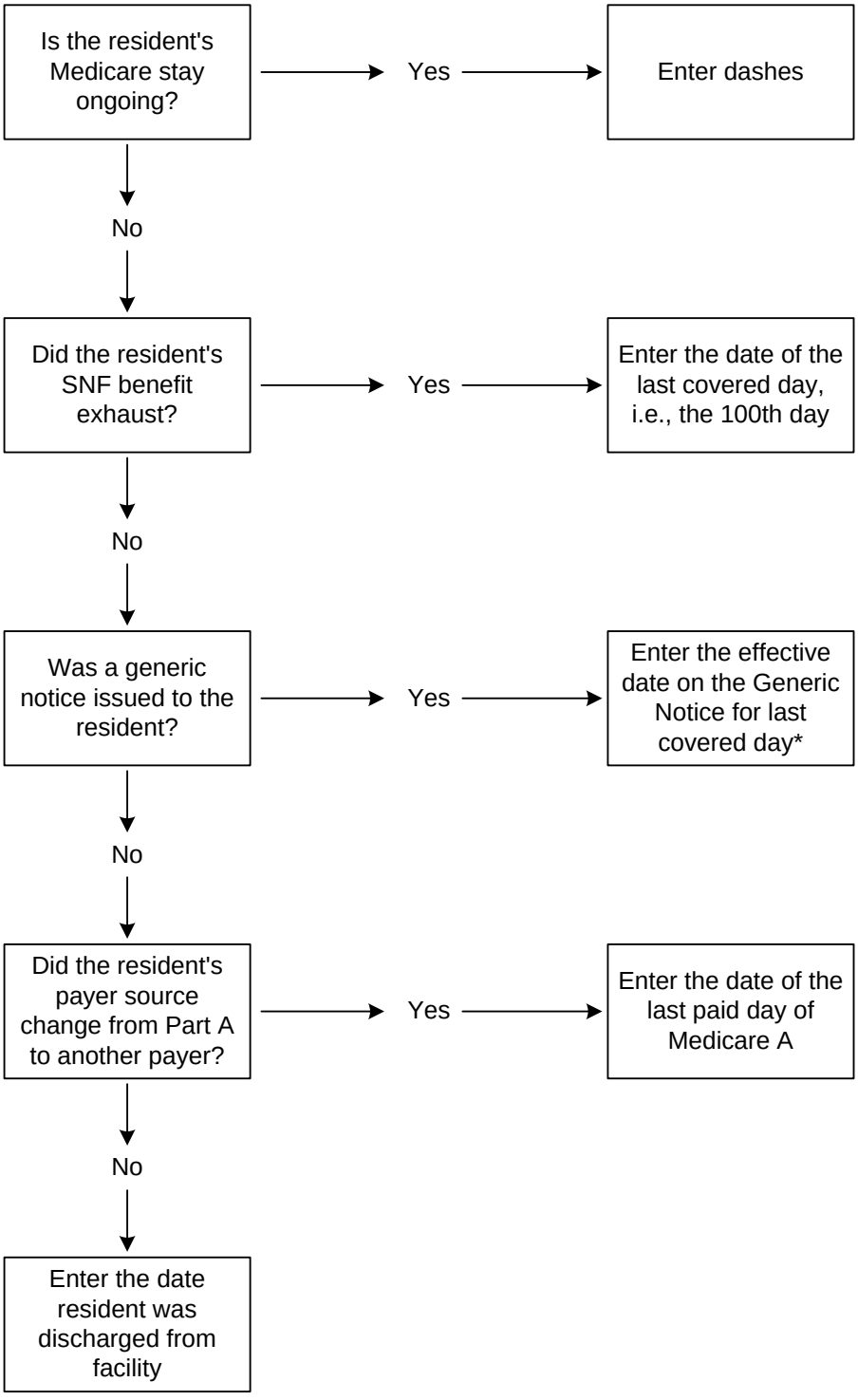
Medicare Stay End Date Algorithm
A2400C


Is the resident's Medicare stay ongoing?
Yes
Enter dashes
No
Did the resident's SNF benefit exhaust?
Yes
Enter the date of the last covered day, i.e., the 100th day
No
Was a generic notice issued to the resident?
Yes
Enter the effective date on the Generic Notice for last covered day*
No
Did the resident's payer source change from Part A to another payer?
Yes
Enter the date of the last paid day of Medicare A
No
Enter the date resident was discharged from facility

*if resident leaves facility prior to last covered day as recorded on the generic notice, enter date resident left facility.

Over the last 2 weeks, about how often have you been bothered by the problem?

Numeric	Descriptive
Never or 1 day	**Never or 1 day**
2 - 6 Days	**Several days**
7 - 11 Days	**Half or more of the days**
12 - 14 Days	**Nearly every day**

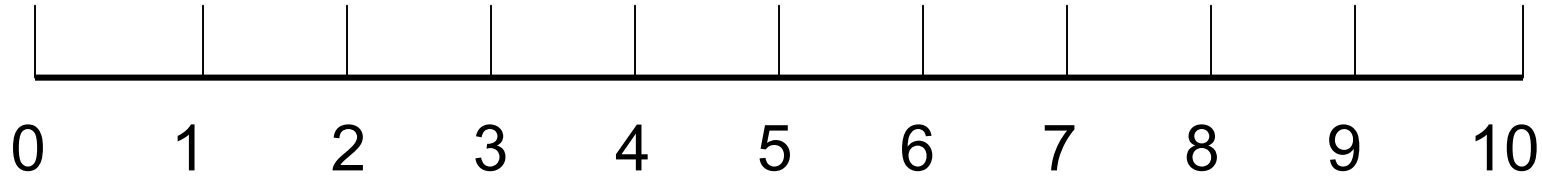
Preferences for Customary Routine and Activities
Symptom Frequency Cue Card
MDS 3.0 F0400 and F0500

While you are in this facility, how important is it to you to…

1. Very important
2. Somewhat important
3. Not very important
4. Not important at all
5. Important, but can't do or no choice

Numeric Rating Scale

Please rate your worst pain over the last 5 days



Verbal Descriptor Scale

Please rate your worst pain over the last 5 days

1. Mild
2. Moderate
3. Severe
4. Very severe, horrible

RRS Healthcare Consulting Services 2010

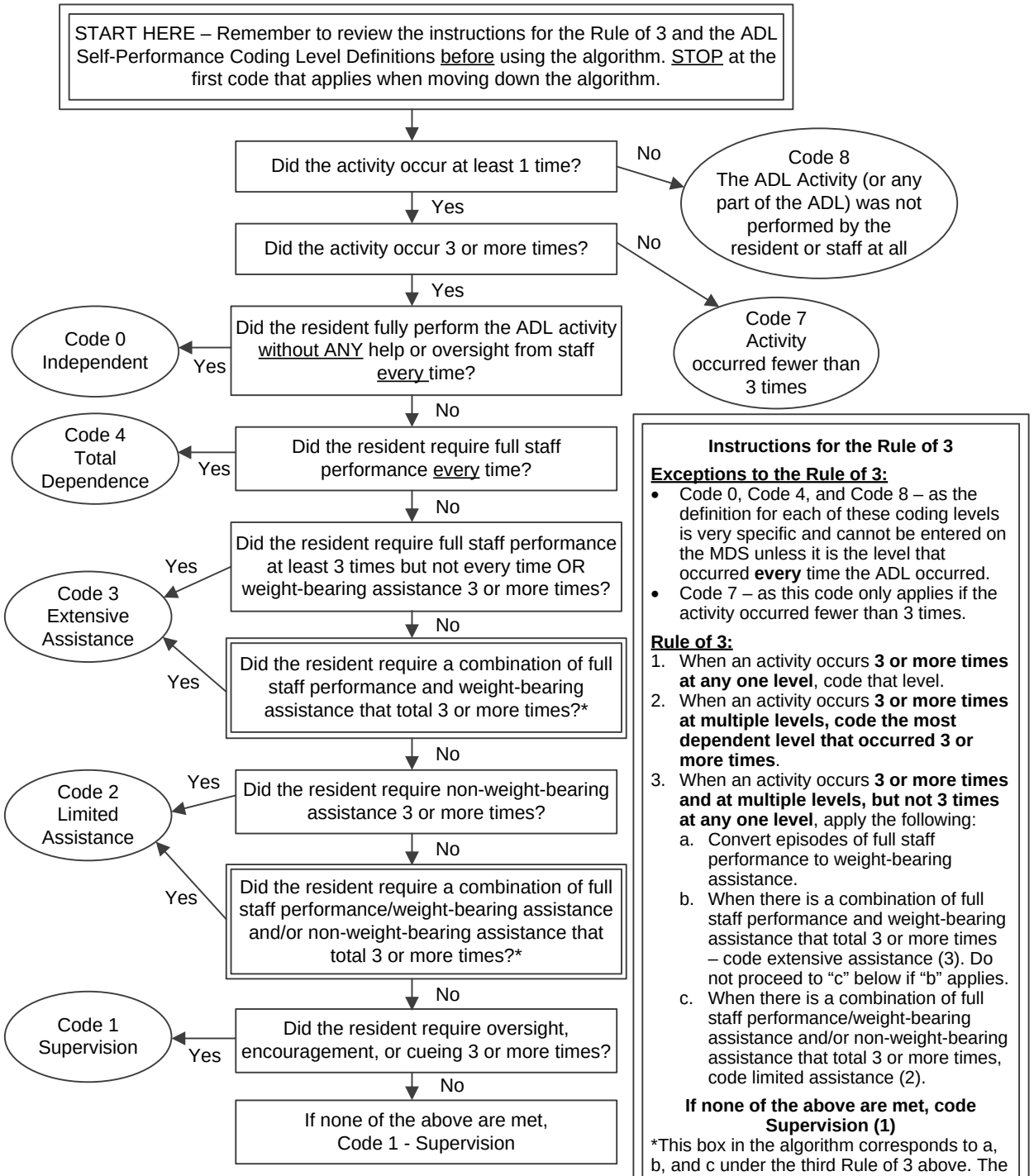
Pain Frequency Cue Card
MDS 3.0 J0400

How much of the time have you experienced pain or hurting over the last 5 days?

1. Almost constantly
2. Frequently
3. Occasionally
4. Rarely

G0110: Activities of Daily Living (ADL) Assistance (cont.)

ADL Self-Performance Algorithm


START HERE – Remember to review the instructions for the Rule of 3 and the ADL Self-Performance Coding Level Definitions before using the algorithm. STOP at the first code that applies when moving down the algorithm.
Did the activity occur at least 1 time?
No
Code 8
The ADL Activity (or any part of the ADL) was not performed by the resident or staff at all
Yes
Did the activity occur 3 or more times?
No
Code 7
Activity occurred fewer than 3 times
Yes
Did the resident fully perform the ADL activity without ANY help or oversight from staff every time?
Yes
Code 0
Independent
No
Did the resident require full staff performance every time?
Yes
Code 4
Total Dependence
No
Did the resident require full staff performance at least 3 times but not every time OR weight-bearing assistance 3 or more times?
Yes
Code 3
Extensive Assistance
No
Did the resident require a combination of full staff performance and weight-bearing assistance that total 3 or more times?*
Yes
No
Did the resident require non-weight-bearing assistance 3 or more times?
Yes
Code 2
Limited Assistance
No
Did the resident require a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that total 3 or more times?*
Yes
No
Did the resident require oversight, encouragement, or cueing 3 or more times?
Yes
Code 1
Supervision
No
If none of the above are met,
Code 1 - Supervision

Instructions for the Rule of 3

Exceptions to the Rule of 3:

- Code 0, Code 4, and Code 8 – as the definition for each of these coding levels is very specific and cannot be entered on the MDS unless it is the level that occurred **every** time the ADL occurred.
- Code 7 – as this code only applies if the activity occurred fewer than 3 times.

Rule of 3:

1. When an activity occurs **3 or more times at any one level**, code that level.
2. When an activity occurs **3 or more times at multiple levels, code the most dependent level that occurred 3 or more times**.
3. When an activity occurs **3 or more times and at multiple levels, but not 3 times at any one level**, apply the following:
   a. Convert episodes of full staff performance to weight-bearing assistance.
   b. When there is a combination of full staff performance and weight-bearing assistance that total 3 or more times – code extensive assistance (3). Do not proceed to "c" below if "b" applies.
   c. When there is a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that total 3 or more times, code limited assistance (2).

If none of the above are met, code Supervision (1)

*This box in the algorithm corresponds to a, b, and c under the third Rule of 3 above. The instruction in this box **only** applies when the third Rule of 3 applies, i.e., an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level (e.g., 2 times non-weight-bearing, 2 times weight-bearing). If the coding scenario does not meet the third Rule of 3, do not apply a, b, or c of the third Rule of 3, answer "No," and then continue down the algorithm.

M0700: Most Severe Tissue Type for Any Pressure Ulcer

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code ☐	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance 3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. **None of the Above**

Item Rationale

Health-related Quality of Life

- The presence of a pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Identify tissue type.

Planning for Care

- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration.

Steps for Assessment

1. Examine the wound bed or base of each pressure ulcer. Adequate lighting is important to detect skin changes.
2. Determine the type(s) of tissue in the wound bed (e.g., epithelial, granulation, slough, eschar).

Coding Instructions for M0700

- Code 1, Epithelial tissue: if the wound is superficial and is re-epithelializing.
- Code 2, Granulation tissue: if the wound is clean (e.g., free of slough and eschar tissue) and contains granulation tissue.
- Code 3, Slough: if there is any amount of slough tissue present and eschar tissue is absent.
- Code 4, Necrotic tissue (eschar): if there is any eschar tissue present.
- Code 9, None of the above: if none of the above apply.

M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

Coding Tips and Special Populations

- Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should **not** be coded as having granulation, slough, or eschar tissue and should be **coded as 1** for this item.
- Code for the most severe type of tissue present in the pressure ulcer wound bed.
- If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar and slough) is present, code for eschar.
- Code this item with **Code 9, None of the above**, in the following situations:

  — Stage 1 pressure ulcer
  — Stage 2 pressure ulcer with intact blister
  — Unstageable pressure ulcer related to non-removable dressing/device
  — Unstageable pressure ulcer related to suspected deep tissue injury

  Code 9 is being used in these instances because the wound bed cannot be visualized and therefore cannot be assessed.

Examples

1. A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer.

   Coding: Code M0700 as 2, Granulation tissue.
   Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound.

2. A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers.

   Coding: Code M0700 as 1, Epithelial tissue.
   Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.

3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound.

   Coding: Code M0700 as 4, Necrotic tissue (eschar).
   Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, [Necrotic tissue (eschar)].

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number ☐	**A. Stage 2**
Enter Number ☐	**B. Stage 3**
Enter Number ☐	**C. Stage 4**

Item Rationale

Health-related Quality of Life

- This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have "worsened" or increased in numerical stage since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.

Planning for Care

- The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.

Steps for Assessment

Look-back period for this item is back to the ARD of the prior assessment. ***If there was no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item.*** *Skip to M1030,* ***Number of Venous and Arterial Ulcers****.*

1. Review the history of each current pressure ulcer. Specifically, compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at an increased numerical stage when compared to the last MDS assessment. This allows a more accurate assessment than simply comparing total counts on the current and prior MDS assessment.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the last MDS assessment was completed.

Coding Instructions for M0800

- Enter the number of pressure ulcers that were not present OR were at a lesser numerical stage on prior assessment.
- Code 0: if no pressure ulcers have increased in numerical stage OR there are no new pressure ulcers.

Coding Tips

- Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis.
- If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.
- Coding worsening of unstageable pressure ulcers:
  - If a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that it is able to be numerically staged. However, if the pressure ulcer subsequently increases in numerical stage after that assessment, it should be considered worsened.
  - If a pressure ulcer was numerically staged and becomes unstageable due to slough or eschar, do not consider this pressure ulcer as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and/or palpated such that the tissues can be identified and the wound restaged, the determination of worsening can be made.
  - If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer's current numerical stage has increased, consider this pressure ulcer as worsened.
  - If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.
  - If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

— If a pressure ulcer increases in numerical stage during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item. While not included in this item, it is important to recognize clinically on reentry that the resident's overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates further and increases in numerical stage on a subsequent MDS assessment, it would be considered as worsened and would be coded in this item.

Examples

1. A resident has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the previous MDS assessment and has now increased in numerical stage to a Stage 3 pressure ulcer.

   Coding: Code M0800A as 0, M0800B as 1, and M0800C as 0.
   Rationale: The pressure ulcer was at a lesser numerical stage on the prior assessment.

2. A resident is admitted with an unstageable pressure ulcer on the sacrum, which is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later. The initial MDS assessment listed the pressure ulcer as unstageable.

   Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.
   Rationale: The unstageable pressure ulcer was present on the initial MDS assessment. After debridement it numerically staged as a Stage 4 pressure ulcer. This is the first numerical staging since debridement and therefore, should not be considered or coded as worsening on the MDS assessment.

3. A resident has previous medical record and MDS documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. Current skin care flow sheets indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, as well as a new Stage 2 pressure ulcer on the left trochanter.

   Coding: Code M0800A as 1, M0800B as 1, and M0800C as 1.
   Rationale: M0800A would be coded 1 because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment. M0800B would be coded 1 and M0800C would be coded 1 for the increased numerical staging of both the sacrum and right heel pressure ulcers.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

4. A resident develops a Stage 3 pressure ulcer while at the nursing home. The wound bed is subsequently covered with slough and is coded on the next assessment as unstageable due to slough. After debridement, the wound bed is clean and the pressure ulcer is reassessed and determined to still be a Stage 3 pressure ulcer.

   Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.
   Rationale: M0800B would be coded 0 because the numerical stage of the pressure ulcer is the same numerical stage as it was prior to the period it became unstageable.

M0900: Healed Pressure Ulcers

M0900. Healed Pressure Ulcers Complete only if A0310E = 0	
Enter Code ☐	**A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?** 0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0900B, Stage 2
	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number ☐	**B. Stage 2**
Enter Number ☐	**C. Stage 3**
Enter Number ☐	**D. Stage 4**

Item Rationale

Health-related Quality of Life

- Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.

M0900: Healed Pressure Ulcers (cont.)

Planning for Care

- Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage.
- **Most Stage 2** pressure ulcers should heal within a reasonable timeframe (e.g., 60 days). Full thickness Stage 3 and 4 pressure ulcers may require longer healing times.
- Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse or backstaging would have permitted identification of this pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e. depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

Steps for Assessment

Complete on all residents, including those without a current pressure ulcer. Look-back period for this item is the ARD of the prior assessment. ***If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.***

1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have healed by the ARD (A2300) of the current assessment.
2. Identify the deepest anatomical stage (see definition on page M-5) of each healed pressure ulcer.
3. Count the number of healed pressure ulcers for each stage.

M0900: Healed Pressure Ulcers (cont.)

Coding Instructions for M0900A

*Complete on **all** residents (**even if M0210 = 0**)*

- Enter 0: if there were no pressure ulcers on the prior assessment and skip to **Number of Venous and Arterial Ulcers** item (M1030).
- Enter 1: if there were pressure ulcers noted on the prior assessment.

Coding Instructions for M0900B, C, and D

- Enter the number of pressure ulcers that have healed since the last assessment for each Stage, 2 through 4.
- Enter 0: if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.

Coding Tips

- Coding this item will be easier for nursing homes that systematically document and follow pressure ulcer status.
- If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location, do **not** consider this pressure ulcer as healed. The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed.

M1030: Number of Venous and Arterial Ulcers

M1030. Number of Venous and Arterial Ulcers	
Enter Number ☐	**Enter the total number of venous and arterial ulcers present**

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

M1030: Number of Venous and Arterial Ulcers (cont.)

Planning for Care

- The presence of venous and arterial ulcers should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheet or other skin tracking form.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any venous or arterial ulcers are present.
    - Key areas for venous ulcer development include the area proximal to the lateral and medial malleolus (e.g., above the inner and outer ankle area).
    - Key areas for arterial ulcer development include the distal part of the foot, dorsum or tops of the foot, or tips and tops of the toes.
    - Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present.
    - Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding.

Coding Instructions

Check all that apply *in the last 7 days.*

Pressure ulcers coded in M0210 through M0900 should ***not*** *be coded here.*

- Enter the number of venous and arterial ulcers present.
- Enter 0: if there were no venous or arterial ulcers present.

M1030: Number of Venous and Arterial Ulcers (cont.)

Coding Tips

Arterial Ulcers

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent.

Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually **no** role in the development of the ulcer.

Example

1. A resident has three toes on her right foot that have black tips. She does not have diabetes, but has been diagnosed with peripheral vascular disease.

   Coding: Code M1030 as 3.

   Rationale: Ischemic changes point to the ulcer being vascular.

M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (i.e. incontinence (IAD), perspiration, drainage)
	None of the Above
☐	**Z. None of the above** were present

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Many of these ulcers, wounds and skin problems can worsen or increase risk for local and systemic infections.

Planning for Care

- This list represents only a subset of skin conditions or changes that nursing homes will assess and evaluate in residents.
- The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present.
    - Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot).

Coding Instructions

Check all that apply *in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.*

Pressure ulcers coded in M0200 through M0900 should ***not*** *be coded here.*

- M1040A, Infection of the foot (e.g., cellulitis, purulent drainage)
- M1040B, Diabetic foot ulcer(s)
- M1040C, Other open lesion(s) on the foot (e.g., cuts, fissures)

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

- M1040D, Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- M1040E, Surgical wound(s)
- M1040F, Burn(s)(second or third degree)
- M1040G, Skin tear(s)
- M1040H, Moisture Associated Skin Damage (MASD) (i.e., incontinence (IAD), perspiration, drainage)
- M1040Z, None of the above were present

Coding Tips

M1040B Diabetic Foot Ulcers

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his other foot.
- Do **not** include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

M1040D Open Lesion Other than Ulcers, Rashes, Cuts

- Do **not** code rashes, skin tears, cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.

M1040E Surgical Wounds

- This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound

M1040F Burns (Second or Third Degree)

- Do **not** include first degree burns (changes in skin color only).

M1040G Skin Tear(s)

- Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.

M1040H Moisture Associated Skin Damage (MASD)

- Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dematitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.

Examples

1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure.

   Coding: This ulcer is not checked at M1040B**. This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210-M0900).**
   Rationale: Persons with diabetes can still develop pressure ulcers.

2. A resident is readmitted from the hospital after myocutaneous flap surgery to excise and close his sacral pressure ulcer.

   Coding: Check M1040E, Surgical Wound.
   Rationale: A surgical flap procedure was used to close the resident's pressure ulcer. The pressure ulcer is now considered a surgical wound.

3. Mrs. J. was reaching over to get a magazine off of her bedside table and sustained a skin tear on her wrist from the edge of the table when she pulled the magazine back towards her.

   Coding: Check M1040G, Skin Tear(s).
   Rationale: The resident sustained a skin tear while reaching for a magazine.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

4. Mr. S. who is incontinent, is noted to have a large, red and excoriated area on his buttocks and interior thighs with serous exudate which is starting to cause skin glistening.

   Coding: Check M1040H, Moisture Associated Skin Damage (MASD).
   Rationale: Mr. S. skin assessment reveals characteristics of incontinence-associated dermatitis.

5. Mrs. F. complained of discomfort of her right great toe and when her stocking and shoe was removed, it was noted that her toe was red, inflamed and had pus draining from the edge of her nail bed. The podiatrist determined that Mrs. F. has an infected ingrown toenail.

   Coding: Check M1040A, Infection of the foot.
   Rationale: Mrs. F. has an infected right great toe due to an ingrown toenail.

6. Mr. G. has bullous pemphigoid and requires the application of sterile dressings to the open and weeping blistered areas.

   Coding: Check M1040D, Open lesion other than ulcers, rashes, cuts.
   Rationale: Mr. G. has open bullous pemphigoid blisters.

7. Mrs. A. was just admitted to the nursing home from the hospital burn unit after sustaining second and third degree burns in a house fire. She is here for continued treatment of her burns and for rehabilitative therapy.

   Coding: Check M1040F, Burns (second or third degree).
   Rationale: Mrs. A. has second and third degree burns, therefore, burns (second or third degree) should be checked.

M1200: Skin and Ulcer Treatments

M1200. Skin and Ulcer Treatments	
↓ **Check all that apply**	
☐	**A. Pressure reducing device for chair**
☐	**B. Pressure reducing device for bed**
☐	**C. Turning/repositioning program**
☐	**D. Nutrition or hydration intervention** to manage skin problems
☐	**E. Pressure ulcer care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☐	**Z. None of the above** were provided

M1200: Skin and Ulcer Treatments (cont.)

Item Rationale

Health-related Quality of Life

- Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing.

Planning for Care

- These general skin treatments include basic pressure ulcer prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific interventions in the care plan.
- If skin changes are not improving or are worsening, this information may be helpful in determining more appropriate care.

Steps for Assessment

1. Review the medical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for residents, so check the nursing facility's policies and procedures and indicate here if administered during the look-back period.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Some skin treatments can be determined by observation. For example, observation of the resident's wheelchair and bed will reveal if the resident is using pressure-reducing devices for the bed or wheelchair.

Coding Instructions

***Check all that apply** in the last 7 days. **Check Z, None of the above were provided**, if none applied in the past 7 days.*

- M1200A, Pressure reducing device for chair
- M1200B, Pressure reducing device for bed
- M1200C, Turning/repositioning program
- M1200D, Nutrition or hydration intervention to manage skin problems
- M1200E, Pressure ulcer care
- M1200F, Surgical wound care

M1200: Skin and Ulcer Treatments (cont.)

- M1200G, Application of non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids.
- M1200H, Application of ointments/medications other than to feet
- M1200I, Application of dressings to feet (with or without topical medications)
- M1200Z, None of the above were provided

Coding Tips

M1200A/M1200B Pressure Reducing Devices

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer. The appropriate reducing (redistribution) device should be selected based on the individualized needs of the resident.
- Do **not** include egg crate cushions of any type in this category.
- Do **not** include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

M1200: Skin and Ulcer Treatments (cont.)

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment (AMDA PU Guideline, page 6). If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and "tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed," (AMDA PU Therapy Companion, page 4).
- It is important to remember that additional supplementation is not automatically required for pressure ulcer management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis (AMDA PU Therapy Companion, page 11).

M1200E Pressure Ulcer Care

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage (M0300A-G)**. Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.

M1200F Surgical Wound Care

- Does not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure Ulcer Care**. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1200: Skin and Ulcer Treatments (cont.)

M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do **not** code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use **M1200E, Pressure Ulcer Care**.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.
- This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages).

M1200H Application of Ointments/Medications Other than to Feet

- Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use **M1200E, Pressure Ulcer Care**.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer**.
- Do **not** code application of dressings to pressure ulcers on the foot, use **M1200E, Pressure Ulcer Care**.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Examples

1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing (redistribution) pad on the wheelchair. The medical record documents delivery of care and notes that the resident is on a 2-hour turning/repositioning

Minutes of therapy for O0400

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.
- If a resident returns from a hospital stay, an initial evaluation must be performed upon readmission to the facility, and only those therapies that occurred since readmission to the facility may be counted.
- The therapist's time spent on documentation or on initial evaluation are not included.
- The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.
- The resident's treatment time starts when he or she begins the first treatment activity or task and ends when he or she finishes with the last apparatus or intervention/task and the treatment is ended, as long as the services were not interrupted (for example, by a bathroom break or a nontherapeutic rest).
- The time required to adjust equipment or otherwise prepare for the individualized therapy of a particular resident, is the set-up time and may be included in the count of minutes of therapy delivered to the resident.
- Include only skilled therapy services. Skilled therapy services must meet the following conditions:
  - — for Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a physician following the therapy evaluation;
  - — the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility that is approved by the physician after any needed consultation with the qualified therapist;
  - — the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
  - — the services must be provided with the expectation, based on the assessment made by the physician of the resident's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;
  - — the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
  - — the services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

- Recreational therapy is not a skilled service according to the Social Security Act. However, for purposes of the MDS, providers should record services for recreational therapy (Item O0400F) when the following criteria are met:
  - — the physician orders recreational therapy that provides therapeutic stimulation beyond the general activity program in the nursing home;
  - — the physician's order includes a statement of frequency, duration, and scope of treatment;
  - — the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by a therapeutic recreation specialist;
  - — the services are required and provided by a state licensed or nationally certified therapeutic recreation specialist or therapeutic recreation assistant, who is under the direction of a therapeutic recreation specialist; and
  - — the services must be reasonable and necessary for the resident's condition.
- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the long-term care facility only if he or she is under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MDS.
- Record only the actual minutes of therapy. The conversion of units to minutes or minutes to units is not appropriate. Do not round to the nearest 5th minute. Please note that therapy logs are not an MDS requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.

Non-Skilled Services

- Services provided, at the request of the resident or family, that are not medically necessary (sometimes referred to as family-funded services) shall not be counted in Item O0400 (Therapies), even when performed by a therapist or an assistant.
- Nursing homes may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services shall not be coded as therapy in Item O0400 (Minutes), since the specific interventions would be considered restorative nursing services when performed by nurses or aides.
- Once the licensed therapist has designed a maintenance program and discharged the resident from rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are not to be reported in Item O0400A, B, or C (Therapies). The services may be reported on the MDS assessment in Item O0500 (Restorative Nursing Program), provided the requirements for restorative nursing program are met.
- Services provided by aides are not skilled services.

APPENDIX D: INTERVIEWING TO INCREASE RESIDENT VOICE IN MDS ASSESSMENTS

All residents capable of any communication should be asked to provide information regarding what they consider to be the most important facets of their lives. There are several MDS 3.0 sections that require direct interview of the resident as the primary source of information (e.g., mood, preferences, pain). Self-report is the single most reliable indicator of these topics. Staff should actively seek information from the resident regarding these specific topic areas; however, resident interview/inquiry should become part of a supportive care environment that helps residents fulfill their choices over aspects of their lives.

In addition, a simple performance-based assessment of cognitive function can quickly clarify a resident's cognitive status. The majority of residents, even those with moderate to severe cognitive impairment, are able to answer some simple questions about these topics.

Even simple scripted interviews like those in MDS 3.0 involve a dynamic, collaborative process. There are some basic approaches that can make interviews simpler and more effective.

- **Introduce yourself** to the resident.
- **Be sure the resident can hear what you are saying.**
  - Do not mumble or rush. Articulate words clearly.
  - Ask the resident if he or she uses or owns a hearing aid or other communication device.
  - Help him or her get the aid or device in place before starting the interview.
  - The assessor may need to offer an assistive device (headphones).
  - If the resident is using a hearing aid or other communication device make sure that it is operational.
- **Ask whether the resident would like an interpreter (language or signing)** if the resident does not appear to be fluent in English or continues to have difficulty understanding. Interpreters are people who translate oral or written language from one language to another. If an interpreter is used during resident interviews, he or she should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the interviewee's responses. The resident should determine meaning based solely on his or her interpretation of what is being translated.
- **Find a quiet, private area where you are not likely to be interrupted or overheard.** This is important for several reasons:
  - Background noise should be minimized.
  - Some items are personal, and the resident will be more comfortable answering in private. The interviewer is in a better position to respond to issues that arise.
  - Decrease available distractions.

- **Sit where the resident can see you clearly and you can see his or her expressions.**
  - — Have your face well lighted.
  - — Minimize glare.
  - — Ask the resident where you should sit so that he or she can see you best. Some residents have decreased central vision or limited ability to turn their heads.
- **Establish rapport and respect.**
  - — The steps you have already taken to ensure comfort go a long way toward establishing rapport and demonstrating respect.
  - — You can also engage the resident in general conversation to help establish rapport.
  - — If the resident asks a particular question or makes a request, try to address the request or question before proceeding with the interview.
- **Explain the purpose of the questions to the resident.**
  - — Start by introducing the topic and explain that you are going to ask a series of questions.
  - — You can tell the resident that these questions are designed to be asked of everyone to make sure that nothing is missed.
  - — Highlight what you will ask.
  - — End by explaining that his or her answers will help the care team develop a care plan that is appropriate for the resident.
  - — Suggested explanations and introductions are included in specific item instructions.
- **Say and show the item responses.**
  - — It is helpful to many older adults to both hear and read the response options.
  - — As you verbally review the response options, show the resident the items written in large, clear print on a piece of paper or card.
  - — Residents may respond to questions verbally, by pointing to their answers on the visual aid or by writing out their answers.
- **Ask the questions** as they appear in the questionnaire.
  - — Use a nonjudgmental approach to questioning.
  - — Don't be afraid of what the resident might say; you are there to hear it.
  - — Actively listen; these questions can provide insights beyond the direct answer.
- **Break the question apart if necessary.** If the resident has difficulty understanding, requests clarification, or seems hesitant, you can employ unfolding or disentangling techniques. (Do not, however, use these techniques for the memory test).

  1. **Unfolding** refers to the use of a general question about the symptom followed by a sequence of more specific questions if the symptom is reported as present. This approach walks the resident through the steps needed to think through the question.

Example: Read the item (or part of the item) to the resident, then ask, "Do you have this at all?" If yes, then ask, "Do you have it every day?" If no, then ask, "Did you have it at least half the days in the past 2 weeks?"

2. **Disentangling** refers to separating items with several parts into manageable pieces. The type of items that lend themselves to this approach are those that include a list and phrases such as "and" or "or." The resident is given a chance to respond to each piece separately. If a resident responds positively to more than one component of a complex item, obtain a frequency rating for each positive response and score that item using the frequency of the component that occurred most often.

   Example: An item asks about "Poor appetite or overeating." Disentangle this item by asking, "Poor appetite?"; pause for a response and then ask, "Or overeating?" If neither part is rated positively by the resident, mark no. If either or both are rated positively, then mark yes.

- **Clarify using echoing.** If the resident appears to understand but is having difficulty selecting an answer, try clarifying his or her response by first echoing what he or she told you and then repeating the related response options.
  - — **Echoing** means simply restating part of the resident's response. This is often extremely helpful during clinical interviews. If the resident provides a related response but does not use the provided response scale or fails to directly answer the question, then help clarify the best response by repeating the resident's own comment and then asking the related response options again. This interview approach frequently helps the resident clarify which response option he or she prefers.
- **Repeat the response options** as needed. Some residents might need to have response choices repeated for each item on a given list.
- **Move on to another question** if the resident is unable to answer.
  - — Even if the interview item cannot be completed the time spent is not wasted. The observation of resident behaviors and attention during the interview attempt provide important insights into delirium, cognition, mood, etc.
- **Break up the interview if the resident becomes tired or needs to leave for rehabilitation, etc.**
  - — Try to complete the current item set and then offer to come back at another time to complete the remaining interview sections.
  - — It is particularly important to complete the performance-based cognitive items in one sitting.
- **Do not try to talk a resident out of an answer.** If the resident expresses strong emotions, be nonjudgmental, and listen.
- **Record the resident's response,** not what you believe he or she should have said.
- **If the resident becomes deeply sorrowful or agitated,** sympathetically respond to his or her feelings.
  - — Allowing emotional expression—even when it is uncomfortable for you as the interviewer—recognizes its validity and provides cathartic support to residents.

- If the resident remains agitated or overly emotional and does not want to continue, respond to his or her needs. This is more important than finishing the interview at that moment. You can complete this and other sections at a later point in time.

- **Resident preferences may be influenced by many factors in a resident's physical, psychological and environmental state, and can be challenging to truly discern.**
  - Residents should be encouraged to articulate their desires and not be strictly limited by their physical limitations and perceived environmental restrictions.
  - When a resident is unable to communicate information about his or her preferences, a family member, close friend, or other representative must be used to complete preference questions. In this case, it is important to emphasize that this person should try to answer based on what the resident would prefer. The resident's preferences while in the nursing home and the resident's current responses when the particular item is offered or provided should form the basis for these responses.

Skills for Effective Interviews

The information in this document is compiled from techniques and scripts provided in the Long-Term Care Facility Resident Assessment Instrument User's Manual *as well as suggestions and examples by the author of this AANAC Education Program manual. It is intended to assist interviewers to become comfortable with the process and not to imply that these are regulatory requirements. See Appendix D of the* Long-Term Care Facility Resident Assessment Instrument User's Manual*, which also can be found in the Source Documents section of this AANAC Education Program Manual, for CMS' official information on this topic.*

Bringing the resident's voice squarely into the midst of the assessment process is critical to being able to provide care that is truly resident-centered and resident-directed. The resident, after all, is the one who knows best what is most important to him or her, his or her preferences, priorities, values, routines, and concerns.

When it comes to interviewing, interviewing skills may be the defining factor between success and lack of success. That's true for the MDS 3.0 interviews as well as any other interviews we do with our residents. So, let's take a look at some of the interview techniques that can help residents to complete the interviews and with responses that are meaningful.

Ensure the environment is conducive to interview

- Private location
- Comfortable seating
- Relaxed atmosphere
- Minimal distractions
- Optimal resident ability to hear

To begin with, ensuring that the interview environment is conducive to interviewing is critical to conducting the interview. First of all, be sure the location is private. And this is something that the facility needs to address from a system perspective, since most residents live in a semi-private room, which doesn't offer much privacy as far as conversation is concerned. Also important are comfortable seating and a relaxed atmosphere for the resident – minimal stress – and minimal noise and activity that might distract the resident.

Another very critical factor is the resident's hearing. Obviously, when a resident doesn't hear everything you're saying, the interview results are not meaningful.
Using a simple hearing device, such as the kind with the head set attached to a cigarette pack- sized amplifier, can make a significant difference. Nurses who know their residents really well often are very surprised at how much more responsive and appropriate some of their residents are when they use such a device.

Explain in simple terms what the process is for the interview

Here is an example using PHQ-9:

"I'm going to be asking you if you have been bothered in the last two weeks by a number of different problems. These are things that we ask everybody because it helps us a lot to be able to meet your needs. Any time you say "yes" to a problem, I will then ask you to tell me how often you were bothered by it in the last two weeks." Then review the answer options with the resident.

Meaning of words and phrases is based on resident's definitions.

The meaning of words and phrases used in the interview questions is based on the resident's definitions. If the resident asks for a definition, let him/her know it means whatever he or she thinks it means. For example, when you say to the resident, "Over the last 2 weeks, have you been bothered by any of the following problems," he might ask you, "Well, what does 'bothered by' mean? Your answer would be something like, "It means whatever you think it means. If you feel that something has bothered you in the last 2 weeks, then it has."

Stick to the script

It is very important to stick to the script. These questions have been tested with nursing home residents and found to be very effective in collecting the kind of information they are intended to collect. If you go too far off script, you run the risk of going down an unintended path. Also, if you try to reword questions too much, their meanings may change, or they may become too open-ended and lose their effectiveness.

Use visual aids, cue cards along with providing verbal instructions

It is very helpful to residents to use a cue card or a paper that has the answer options written in large print that they can refer to each time you review them.

With long answers, summarize (echo) the answer ("You're saying that…") and then ask which response option represents what he said and review the response options

This technique can be very helpful in refocusing the resident. It's called "echoing." This is useful when you get a sort of long, winding answer from the resident that's really not on point. In that case, you would summarize – or echo – what he said. You might say, for example, "You're saying that…" and then summarize briefly and then ask which response option represents what he said – and then review the response options with him again. Echoing also should be used whenever a resident provides a response to validate that you heard what was said and to help the resident maintain focus.

Help to narrow the response when necessary (unfolding)

Unfolding is a technique that can help to narrow the response when the resident is trying to figure out how often something has occurred. Here is an example from the PHQ-9 of how the conversation might go:
Q. "Over the last two weeks, have you been bothered by trouble falling or staying asleep or sleeping too much?"
A. I've always had a lot of trouble falling asleep.
Q. "You've always had trouble falling asleep. In the last two weeks, did it happen nearly every day or was it more like just one day in the last two weeks?"
A. Oh, closer to one day
Q. "Closer to one day. Was it less than half the days?"
A. Yes, I think so.
Q. "So it was less than half the days. Do you think it was just one day or several days?"
A. Oh, it was more than one day, so – several days.

Here is another example:

Q. "How important is it to you to have books, newspapers, and magazines to read while you're in this facility?" [Review answer options with resident]
A. Well, I've always enjoyed reading a lot – but I'm not sure what I can do here.
[Since that response really doesn't answer the question, the interviewer might respond as follows]
Q. "You've always enjoyed reading – is it important to you to have books and newspapers and magazines to read while you're here?"
A. Well, yes, I think so."
The interviewer would then help him to narrow the answer in terms of importance via unfolding by reviewing the answer options with the aid of the visual aid again.

Break lists into component parts (disentangling) and obtain a rating for each when necessary

Another technique called disentangling can really help the resident when the question contains multiple symptoms to address. Here is an example of how this conversation might go, again using a question from the PHQ-9 interview.
Q. "Over the last two weeks, have you been bothered by trouble falling or staying asleep or sleeping too much?"
A. Falling asleep or… what did you say?
Q. "Let's try this a bit differently. Over the last two weeks, have you been bothered by trouble falling asleep?"
A. Yes, I have.
Q. "You've been bothered by trouble falling asleep. How often did that happen in the last two weeks?"
[Review answer options for frequency]
A. Oh, at least half the time.

Q. “Okay, thank you. Over the last two weeks, have you been bothered by trouble staying asleep?”
A. Yes, I have.
Q. “You’ve had trouble staying asleep. How often did that happen in the last two weeks?”
[Review answer options for frequency]
A. “Oh, just a couple of days – 2 to 6.
Q. “Okay. And over the last two weeks, have you been bothered by sleeping too much?”
A. No, no, I haven’t.

Now that you have the responses for all three symptoms, on the MDS you would code the one with the highest frequency. In this case, that would make the frequency “7-11 days”, “half or more of the days.”

In the process of conducting the interview, it is important to avoid drawing conclusions about what the resident’s answer is based on a more general response. For example, consider this exchange:

Q. “Over the last two weeks, have you been bothered by trouble falling or staying asleep or sleeping too much?”
A. I've always had a lot of trouble falling asleep.

It might be tempting to code Symptom Presence as Yes and Symptom Frequency as 12-14 days (nearly every day). However, this answer actually is non-responsive – the question is very specific to the last two weeks, and the resident hasn’t addressed that time period.

Successful interviewing often requires patience. Interviewers should schedule sufficient time for the interview, ensuring that if the need arises for the techniques that will help the resident to answer the questions honestly and accurately, a sense of rushing, which can adversely affect the process, will not be injected into the interview.